

This medical record is **confidential** and will not be released to anyone except as may be required by law.

St. Croix County DHHS-Public Health Dept.

Date \_\_\_\_\_

Reproductive Health

1752 Dorset Lane, New Richmond, WI 54017

Client # \_\_\_\_\_

715-246-8365 Fax 715-246-8298

## PREGNANCY HEALTH HISTORY

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Last First M

Please circle if you are allergic to:

☐ **No Allergies**

☐ Penicillin

☐ Iodine

☐ Zithromax

☐ Doxycycline

☐ Sulfa

☐ Metal

☐ Rocephin

☐ Tetracycline

☐ Latex

☐ Local anesthetic

☐ Amoxicillin

☐ Other \_\_\_\_\_

List medications, vitamins, over-the-counter drugs, and/or herbs you take: \_\_\_\_\_

Have you or your partner recently traveled to a region with known Zika or Ebola transmission? Yes No If yes, where: \_\_\_\_\_

### REASON FOR YOUR VISIT –PREGNANCY TESTING:

Are you planning a pregnancy at this time? ☐ Yes ☐ No

If you are pregnant, will you feel? ☐ Happy ☐ Not sure ☐ Sad ☐ Worried ☐ Other: \_\_\_\_\_

If you are pregnant, will you proceed with the pregnancy? Yes No Uncertain

Circle if you want information on: Financial assistance, Nutrition (WIC), Prenatal care, Abortion, Adoption, Infant care, Parenting

### MENSTRUAL HISTORY

When was the 1<sup>st</sup> day of your last period: \_\_\_\_/\_\_\_\_/\_\_\_\_ Was it Normal? ☐ Yes ☐ No

Have you had sex since your last period? ☐ Yes ☐ No When: \_\_\_\_\_

Since your last period, have you had any of the following?: (circle all that apply)

☐ breast tenderness ☐ fatigue ☐ increased urination ☐ nausea or vomiting ☐ pain in your lower abdomen

### SEXUAL HISTORY Age of first intercourse: \_\_\_\_\_

Have you had a new partner or more than one partner in the last 90 days? ☐ Yes ☐ No ☐ Don't know

Has your partner(s) had a new sex partner or more than one partner in the last 90 days? ☐ Yes ☐ No ☐ Don't know

Have you ever engaged in a sexual activity where you felt you couldn't say no? ☐ Yes ☐ No

Circle if you have: vaginal sex ☐ oral sex ☐ anal sex ☐ sex with men ☐ sex with women ☐ sex with both

Have you ever had? ☐ Chlamydia ☐ Gonorrhea ☐ HPV/warts ☐ Herpes ☐ Syphilis ☐ HIV

Have you had symptoms or diagnosis of a sexually transmitted infection in the last 90 days? ☐ Yes ☐ No ☐ Don't know

Has your partner had symptoms or diagnosis of a sexually transmitted infection in the last 90 days? ☐ Yes ☐ No ☐ Don't know

### PREGNANCY

How many times have you been pregnant? \_\_\_\_\_

Dates when your pregnancy(ies) ended: \_\_\_\_\_

Have you ever had an ectopic (tubal) pregnancy? ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

### REPRODUCTIVE LIFE PLAN

Do you hope to have any (more) children? ☐ Yes ☐ No How many children do you hope to have? \_\_\_\_\_

How long do you plan to wait until you (next) become pregnant? \_\_\_\_\_

What do you plan to do until you are ready to get pregnant? \_\_\_\_\_

What can I do today to help you achieve your plan? \_\_\_\_\_

CONTRACEPTION: Are you currently using a birth control method? ☐ No ☐ Yes, what kind: \_\_\_\_\_

When did you last use birth control: \_\_\_\_\_

If your pregnancy test is negative: Do you want a method of birth control? Yes No ☐ What kind? \_\_\_\_\_

Do you want emergency contraception/condoms? Yes No

Do you want a physical exam? Yes No

Do you want preconceptional planning? Yes No

Does your sexual partner(s) agree with your decision to prevent pregnancy and use birth control at this time? ☐ Yes ☐ No

Has anyone ever done anything to your birth control? ☐ Yes ☐ No (i.e., thrown away your pills, patches, rings, or taken his condom off before or during sex)

### SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes \_\_\_\_ # per day. Do you want to quit ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes Do you use street drugs? ☐ No ☐ Yes

Does alcohol/drugs cause problems in your life and/or are others concerned? ☐ No ☐ Yes

Do you feel threatened or afraid of someone in your life? ☐ No ☐ Yes

Do you have any concerns about: ☐ Date rape ☐ Forced/unwanted sex ☐ Physical abuse ☐ Weight

Have you ever received medical care/medications for your mental health? ☐ No ☐ Yes

### PAST MEDICAL HISTORY

Do you have a health care provider if you are pregnant? ☐ No ☐ Yes If yes, name & clinic: \_\_\_\_\_

To the best of my knowledge, the above information is complete and accurate and I request a pregnancy test.

Revised 04/2017